



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CONCHO COUNTY HOSPITAL
PO BOX 987 614 EAKER ST
EDEN TX 76837

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-7538-01 (PREVIOUSLY M4-08-7065-01)

MFDR Date Received

JULY 29, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "No Payment."

Amount in Dispute: \$783.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The date of service in question is being denied due to the fact that the compensable injury is limited to a laceration/puncture wound of the left hand only. The provider is billing for an ankle sprain. Attached is the DWC-1 and PLN-11 that was filed with the Division of Workers' Compensation. Therefore, the carrier maintains its nonpayment of these services."

Response Submitted by: AIG, 2929 Allen Parkway, Suite 1300, Houston, TX 77019

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2007	Outpatient Hospital Services	\$783.45	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 1 (51) – These are non-covered services because this is a pre-existing condition.

- 2 (150) – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 29 – The time for filing has expired.

Findings

1. The insurance carrier submitted a PLN-11 for date of injury July 24, 2007 stating “the carrier accepts injury in the form of a laceration/puncture wound to the left hand only. Carrier denies that the accepted injury extends to and/or includes any other body part of condition. Carrier is not responsible for any pre-existing injury of the claimant’s condition and/or disability.”
2. Review of the submitted documentation shows that the carrier audited the disputed date of service with the date of injury of July 24, 2007 instead of the date of injury September 14, 2007. The health care provider requested a benefit review conference; however, this was canceled as there was no extent of injury for the September 14, 2007 date of injury. Therefore, the disputed date of service will be reviewed in accordance with the Texas Labor Code and Division rules.
3. The carrier denied the services using denial code 29 – “The time limit for filing has expired.” Review of the initial EOB, with a processing date of November 21, 2007 confirms that the requestor timely submitted the bill for audit. The respondent reviewed the date of service under the incorrect date of injury of July 24, 2007. Therefore, the denial reason is not supported and the dispute will be reviewed in accordance with the Texas Labor Code and Division rules.
4. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. 28 Texas Administrative Code §133.307(c)(2)(F)(ii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a position statement of the disputed issue(s) that shall include . . . the requestor’s reasoning for why the disputed fees should be paid or refunded.” Review of the submitted documentation finds that the requestor has not discussed the reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(ii).
7. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a position statement of the disputed issue(s) that shall include . . . how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues.” Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
8. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include “a position statement of the disputed issue(s) that shall include . . . how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
9. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should

be calculated.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 1, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.